STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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A 000	INITIAL COMMENTS MEDICARE COMPLAINT SURVEY 3rd FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint follow-up survey. Onsite dates: 09/10/18 to 09/12/18 The survey was conducted by: Surveyor #5 Surveyor #11 DOH staff found the facility has substantially corrected all Condition-level deficiencies cited during the 07/16/18 - 07/17/18 hospital complaint survey follow-up visit. During the course of the survey, surveyors assessed issues related to complaint intake #80538 and #84468. DOH staff found the facility in substantial compliance with all Conditions of Participation set forth in 42 CFR, Acute Care Hospitals except those standard-level deficiencies listed below.	A 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 days from the date you receive the Statement of Deficiencies. 4. Return the ORIGINAL REPORT with the required signatures.	
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:]	A 068		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 rs following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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A 068	Continued From page 1 A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the Governing Body failed to develop and maintain an effective system to ensure that physicians monitored and met the patient's nutritional needs for 3 of 4 patients reviewed (Patient #501, #503, and #504). Failure to develop an effective system to provide for patient's nutritional needs risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutrition Screen and Assessment," no policy number, revised date 08/18, showed that nutrition screens would be reviewed and signed by the licensed dietician when requested by the physician or nursing staff. During the nutritional assessment, the dietician would determine the need for a diet change and would make recommendations for a specific diet	A 068		

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A 068	Continued From page 2 for the patient. These recommendations would be relayed to the attending physician or treatment team as appropriate. 2. During the survey, Surveyor #5 reviewed the records of three patients currently being treated at the hospital and interviewed hospital staff members. The record reviews and interviews showed the following: a. Patient #501: 1) 09/10/18 at 10:20 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Program Director (Staff #504) reviewed the medical record for Patient #501. This patient had been admitted on 05/31/18 for the treatment of Schizophrenia, Secondary Dissociative Disorder, and Command Auditory Hallucinations to harm self. The record review showed the following: a) Patient #501 was referred for a dietary consult on 06/10/18 due to "poor intake." At that time, the dietician's nutritional assessment showed the patient had a 4 pound 2 ounce weight loss in 1 week. The dietician recommended a) a high protein milkshake once daily; b) Ensure® (a nutritional supplement or meal replacement) after each meal when oral intake was less than 50%; and c) to measure and record the patient's weight. b) Nursing documentation on 08/27/2018 and 08/28/2018 showed that the patient continued to have poor dietary intake and was refusing the supplements. c) The dietician completed a nutritional assessment on 08/28/18. The assessment	A 068		

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A 068	Continued From page 3 showed that Patient #501 had lost 10 pounds since admission. The dietician recommended offering chocolate Ensure® if meal intake was less than 50% and providing a high protein milkshake two times daily. The dietician follow-up plan included a weight check and further discussion with the patient about her intake in one week. There was no evidence in the patient's medical record that showed the dietician completed a follow-up review or weight check concerning the patient's poor dietary intake and weight loss. d) A Psychiatric Progress Note completed on 08/29/18 at 12:00 PM stated, "Sleep and appetite are fair. Continue stabilization and follow up with family services. Continue current milkshakes daily." Surveyor #5 found no evidence the healthcare provider had reviewed the dietician's 08/28/18 recommendation to increase the milkshakes to twice a day. e) Documentation on the Daily Nursing Progress Notes showed that from 08/26/18 through 09/09/18 (a period of 15 days), the patient ate less than 50% of his/her meal for 19 of 41 meals served. There was no documentation in the patient's record that showed the patient received Ensure® when her meal intake was less than 50%. f) On 08/29/18, review of the patient's medication administration record (MAR) showed an order change to increase the high protein milkshake to twice daily. Staff documented the patient received the high protein shake at 9:00 AM and 2:00 PM. The next day, on 08/30/18 the MAR showed the patient was to receive the high protein milkshakes once daily per physician order dated 06/15/18.	A 068		

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A 068	Continued From page 4 Review of the MAR dated 08/30/18 to 09/10/18 continued to show that the patient order for protein milkshakes was once per day rather than twice per day as recommended by the dietician. 2) On 09/10/18 at 12:00 PM, during an interview with Surveyor #5, the Dietician (Staff #506) stated that a provider did not need to write a diet order and that the dietician consultation was enough. The dietician was unaware of the revised nutritional assessment and screening procedure that stated the dietician only made recommendations for diet orders. She stated that Patient #501 should be receiving the high protein shakes twice daily. She stated that she did not know if the patient was receiving the Ensure® supplements and she did not know where staff documented how much of the dietary supplement the patient consumed. The dietician confirmed she had not followed up with the patient nor weighed the patient per the nutrition consultation plan. She verified there were no other weights documented. At the time of the interview, the dietician did not know if the patient was gaining or losing weight. 3) On 09/10/18 at 12:15 PM, during an interview with Surveyor #5, the Program Director (Staff #508) verified the instances of meal intake less than 50% and confirmed there was no documentation of the Ensure® supplements. She verified there were no documented weights on the "neurological/vital signs check/weights" flow sheet. She stated there were no weights documented because the only provider order was to take the patient's weight once on admission (05/31/18). She stated that although the dietician made a recommendation for the high protein shakes twice daily for weight loss, the provider	A 068		

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A 068	Continued From page 5 must write an order. She stated because the provider did not write an order, the patient should not have received the high protein shake twice on 08/29/18 and the correct order was the order written by the provider on 06/15/18. 4) On 09/10/18 at 12:50 PM, a Licensed Practical Nurse (Staff #507), stated that the high protein drinks and the Ensure® supplements were to be documented either on the MAR or in a nursing progress note. Surveyor #5 found no evidence staff offered or documented the Ensure® supplements. Surveyor #5 questioned Staff #507 about the missing documentation in Patient #501's medical record. Staff #507 stated that there was no standardized process for documenting administration of dietary supplements. b. Patient #503: 1) On 09/11/18 at 11:40 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #510) reviewed the medical record for Patient #503. This patient had been admitted on 09/07/18 for the treatment of suicidal ideation and suicide attempt. The record review showed the following: a) A Laboratory report for a complete blood count collected on 09/07/18 showed that the patient's triglyceride level was 100 mg/dL (high). The lab reference showed 0-89 mg/dL as normal. b) On 09/09/18 at 11:30 AM, a healthcare provider (Staff #511) wrote an order for a dietary consult for diet modification related to elevated triglycerides. c) On 09/10/18 at 11:19 AM, the dietician (Staff	A 068		

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A 068	Continued From page 6 #506) completed a dietary consultation and documented the consult on a "Nutrition Assessment Form." The dietician recommended a fasting triglyceride lab test to assure the correct level and to start a heart healthy meal plan. 2) On 9/11/18 at 12:00 PM, Surveyor #5 asked a registered nurse (RN) (Staff #510) if the provider had reviewed the recommendations from the dietician. The RN stated she did not know if the provider had reviewed the consultation and verified there was no documentation in the chart to confirm the provider had reviewed the dietary consult. c. Patient #504: 1) On 09/12/18 at 9:22 AM, Surveyor #5, the Senior Clinical Vice-President of Compliance (Staff #501), and a Registered Nurse (RN) (Staff #512) reviewed the medical record for Patient #504 who was admitted on 08/12/18 for the treatment psychosis, depression and suicidal ideation. The record review showed the following: a) On 08/12/18 at 5:50 PM, the admitting healthcare provider ordered a dietary consult. b) The Psychiatric Evaluation completed on 08/13/18 at 11:00 AM showed that the patient's mother reported the patient had decreased appetite and had lost 20 pounds over the past month. The healthcare provider wrote an order for a dietary consult for gluten-free diet due to a weight loss of plus or minus 20 pounds in plus or minus one month. d) The dietician completed the consultation on 08/14/18 at 2:20 PM. The dietician noted in the	A 068		

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A 068	Continued From page 7 assessment that the patient has lost plus or minus 20 pounds in the past month and reported lab values that showed a low total protein level of 5.9 (Normal range 6.0 to 8.3 grams per deciliter (g/dL). The dietician recommended nutritional supplements to optimize caloric and protein intake, and recommended high-protein nutritional milkshakes two times daily at 10:00 AM and 2:00 PM. e) On 09/04/18 at 10:00 AM, a healthcare provider wrote an order to discontinue the protein shakes. Surveyor #5 found no evidence a provider had ordered the high protein shakes. The Registered Nurse (RN) (Staff #512) stated that the patient was not receiving high protein shakes. f) Documentation showed one patient weight taken on admission to the hospital. 2) On 09/12/18 at 9:40 AM, Surveyor #5 asked the Senior Clinical Vice-President of Compliance (Staff #501) if the provider had reviewed the dietician consultation and recommendations. Staff stated that she did not know, and after review of the documentation, confirmed there was no way for staff to identify if the provider reviewed the dietary consultation. At this time, she confirmed there was no provider order for high protein shakes, and staff had not weighed the patient since admission. 3) On 09/12/18 at 10:00 AM, Surveyor #5 reviewed the medical record a second time with a dietician (Staff #506) and the Chief Nursing Officer (Staff #502). Surveyor #5, Staff #506 and Staff #502 discussed the patient's "fair" meal intake noting the patient's meal intake ranged	A 068		

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A 068	Continued From page 8 from 0% to 100%, but averaged around 50%. Staff #502 stated that it appeared that the patient had decreased intake around times of worsening psychological status. At this time, the dietician (Staff #506) stated that she did not know if the patient received the high protein shakes or not, and she did not know if the provider ordered the high protein shakes. Surveyor #5 asked Staff #502 how she communicated a patient's nutritional status or nutrition concerns and if she attended the patients treatment team meetings. Staff #502 stated she did not attend the treatment team meetings, but that sometimes she would ask providers to write orders when she saw them.	A 068		
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure hospital staff members followed the policy and procedure for patient safety checks for 1 of 2 occurrences reviewed. Specifically, hospital staff members did not complete an incident report when contraband was found in a patient's room, and hospital administration did not investigate how the contraband was brought into the hospital Failure to report, investigate, and prevent contraband and other hazardous items from being brought into the hospital risks patient, visitor, and staff injury. Findings included:	{A 144}		

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{A 144}	Continued From page 9 1. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number, revised date 06/18, showed that hospital staff members would search patient rooms for contraband at least twice daily. Contraband included prohibited items such as illegal drugs and paraphernalia. The policy showed that when staff discovered contraband, hospital staff would confiscate the items; immediately notify the patient, the patient's healthcare provider, and the Chief Nursing Officer; and complete an incident report. 2. On 09/11/18, Surveyor #5 reviewed the medical record for discharged Patient #502 who had been admitted on 08/04/18 for the treatment of psychosis and schizophrenia. The record review showed that on 08/06/18 at 4:21 PM a healthcare provider ordered a urine drug screen. On 08/07/18 at 5:00 AM, the urine drug screen showed a positive result for methamphetamine. A "Daily Nursing Progress Note" dated 08/07/18 showed that on at 1:00 PM staff discovered a syringe filled with black fluid in the patient's room during a routine room search. 3. On 09/11/18 9:00 AM, Surveyor #10 reviewed the hospitals incident report log. Surveyor #10 found no evidence that staff had completed an incident report following the event above. Surveyor #10 found no evidence that the hospital conducted an investigation of the incident. 4. On 09/11/18 at 9:30 AM, Surveyor #5 and Surveyor #10 discussed the finding with the Director of Process Improvement and Risk (Staff #505). Staff #505 stated there were no incident reports related to contraband in August 2018. He	{A 144}		

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{A 144}	Continued From page 10 stated he was "aware" of the incident, but could not locate an incident report. 5. On 09/11/18 at 11:05 AM during interview with Surveyor #5, a Registered Nurse (RN) (Staff #514) stated that the staff conducted contraband checks twice daily, once on day shift and once on night shift. The RN stated that a Licensed Practical Nurse (LPN) (Staff #507) and a Mental Health Technician (MHT) (Staff #513) told him about the syringe of methamphetamine after they found it under a mattress in the patient's room on 08/07/18. He stated the LPN and the MHT disposed of the syringe. He stated that he went to the office of Staff #502 and reported the incident. He stated he remembered going to her office, as he was feeling "panicky because (he) had never had this happen before and (he) needed guidance." He stated that Staff #502 told him to document the incident in the chart. He stated he did not remember if he completed an incident report. He stated he asked the patient how she got the methamphetamine the patient stated that she did not want to talk about it. 6. On 09/11/18 at 11:29 AM, Surveyor #5 interviewed the hospital's Chief Nursing Officer (CNO) (Staff #502). Staff #502 stated that she was aware of the incident, but could not recall talking with Staff #514 in her office or recall the outcome of the incident. She stated that at the time of the incident, she was working as the Director of Infection Prevention and Education, not as the hospital's CNO. 7. On 09/11/18 at 1:00 PM, Staff #505 presented Surveyor #5 and Surveyor #10 with an incident report completed that day by the MHT (Staff #513) who found the syringe.	{A 144}		

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{A 144}	Continued From page 11 8. On 09/11/18 at 1:35 PM, Surveyor #5 interviewed Staff #513 regarding contraband, room searches, body searches, and the incident report process. Staff #513 stated that staff conducted contraband checks twice daily, once on day shift and once on night shift. Staff #513 told the Surveyor that when he found the contraband he reported the incident to the charge nurse and the Chief Nursing Officer. Surveyor #5 asked Staff #513 if he filled out an incident report at the time of the incident and he stated he did not remember if he filled one	{A 144}		